WILLIAMSON COUNTY

DEPENDENT SUPPLEMENTAL LIFE COVERAGE ENROLLMENT FORM

Supplemental Dependent Life Policy Number #93624

Employee Name: _____ **Employee Social Security#:** _____
Employee Address: _____ **City, State, Zip:** _____

Supplemental Life Insurance - Spouse

If you elect the Supplemental Life plan for yourself, you may elect Supplemental Life coverage for your Spouse. Your election may be made in increments of $5,000 to a maximum of $100,000. This amount may not exceed 50% of your approved Supplemental Life election. If you elect an amount that exceeds the guaranteed issue amount of $50,000, your spouse will need to provide evidence of good health that is satisfactory to Sun Life before the excess can become effective. Use the rate chart and calculation line below to determine your approximate monthly cost for this coverage.

I understand that any coverage I am requesting is subject to all the terms of the policy including any exclusions, any provisions requiring the submission of evidence of good health and approval by Sun Life. Any provisions specifying a Delayed Effective Date in the event that I am absent from work or an eligible dependent is totally disabled on the date coverage would otherwise begin.

Age	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	$0.255	$0.335	$0.470	$0.725	$1.175	$1.975	$3.10	$4.12	$6.66	$11.885	$20.70

☐ I elect to **enroll** my Spouse in the Supplemental Life plan at the monthly cost below.*

_____ ÷ $5,000 = _____ x _____ = $_____
Elected Benefit Amount — Rate Above — Your Monthly Cost*

Spouse Name_____ **Spouse Date of Birth**_____
Spouse Social Security#_____

☐ I elect to **decline** the Supplemental Life plan for my Spouse and know that Evidence of Insurability will be required if I decline and then want to enroll at a later date.

Please Note-
*Evidence of good health is not required for enrollment of a spouse during the initial new hire enrollment period unless you exceed the Guarantee Issue amount of $50,000.
*Enrollment at time of marriage (when election is made within 30 days of marriage) does not require evidence of insurability unless you exceed the Guarantee Issue amount of $50,000.
*Enrollment of an eligible spouse after initial enrollment as a new hire will require evidence of insurability.

Supplemental Life Insurance - Child(ren)

If you elect the Supplemental Life plan for yourself, you may elect Supplemental Life coverage for your Dependent Child(ren) between the ages of 15 days and 19 years (25 years if a full time student). **The maximum death benefit for a child between the ages of live birth and 6 months is $1,000.** Your election may be made in increments of $2,500 to a maximum of $10,000. Use the chart below to determine your approximate monthly cost for this coverage.

Child Life Amount	$2,500	$5,000	$7,500	$10,000
Monthly Cost	$0.40	$0.80	$1.20	$1.60

☐ I elect to **enroll** my dependent child(ren) in the Supplemental Life plan for $_____ at the monthly cost of $_____.

Please provide name(s) and date of birth for child(ren) enrolling:

Childs Name_____ **Childs Date of Birth**_____ **SS#**_____

Childs Name_____ **Childs Date of Birth**_____ **SS#**_____

Childs Name_____ **Childs Date of Birth**_____ **SS#**_____

☐ I elect to **decline** the Supplemental Life plan for my dependent child(ren) and know that Evidence of Insurability will be required if I decline and then want to enroll at a later date.

Please Note-
*Enrollment for newborns (when election is made within 30 days of birth) does not require evidence of good health.
*Enrollment of an eligible dependent child(ren) after initial enrollment as a new hire will require evidence of good health. You must complete an evidence of good health for each dependent.

Employee Confirmation

I have been given the opportunity to enroll in Williamson County's group Supplemental Life and AD&D & LTD Insurance plans. I understand that if I decline now, but later decide to enroll, I will be required to provide evidence of good health that is satisfactory to Sun Life and understand my request for coverage may be denied. I authorize my employer to make the appropriate payroll deductions from my wages on a post-tax basis.

Employee Signature: _____ Date: _____

Beneficiary Designation is automatically assigned to the above Employee electing coverage.
Please sign this form and return to the Williamson County Benefits Department.

11/05/2007